D R A F T

VSH Futures Advisory Committee
June 26, 2006

Minutes

Next committee meeting: August 7, 2006 2:00 – 4:30 p.m. Skylight Conference Room, State Office Complex, Waterbury

Meeting Participants

AHS Secretary Cindy LaWare and AHS Deputy Secretary Steve Gold

Advisory Committee Members: Jackie Leman, peer support HCHS: Linda Corey, VPS; Kitty Gallagher, VPS; JoEllen Swaine, VSH; Lawrence Thomson, VSH; David Fassler, MH SA Professionals; Conor Casey, VSEA; Nick Emlen (for Paul Dupre, VT Coucil), Michael Hartman, WCMHS & DA Consortium; Diane Bogdan, DOC (for Janice Ryan); Stan Baker, DS/HCHS; Jeff Rothenberg, CMC/CRT; Jack McCullough, MH Law Project; Larry Lewack, NAMI-VT; Sandra Steingard, HCHS; Sally Parrish, Peer; Bea Grause, VAHHS

Guests: Bruce Spector, BISHCA; Julie Tessler, VT Council; Roy Ruddle, WCMH; Morgan Brown, Peer.

Staff: Beth Tanzman, Dawn Philibert, Judy Rosenstreich, Norma Wasko, VDH; Wendy Beinner, AAG

Agenda:

I. Continued Work on Reducing Coercion and the Programs in the Futures Plan: Practical Steps to Realize our Vision

"Vermont law directs that it be our policy 'to work towards a mental health system that does not require coercion or the use of involuntary medication.' In light of this policy, at every point in our planning process, we should be seeking ways to reinforce a system that maximizes reasonable choices of voluntary services and avoids or minimizes involuntary treatment. While acknowledging that court-ordered or involuntary care is sometimes required, we ask that these recommendations be read with this policy in mind."
"Recommendations for the Future of Services…" Secretary Charlie Smith, 2/4/05, p.2

- Discussion: Review of matrix suggested by committee member Larry Lewack

Public Comment

II. Work Group Reports

- Care Management: change In Level of Care
- VSH Employee
- Architectural
- Community Residential Recovery
- Housing
- Crisis Beds

Public Comment

III Updates
- Mental Health Legislative Oversight Committee
- Work with the City of Burlington
- Certificate of Approval Process

Futures Project Director Beth Tanzman opened the meeting on behalf of Paul Blake who was on vacation, and introduced Norma Wasko, new staff for the Futures Project.

Minutes of the June 12 meeting were distributed.

Linda Corey reported that the Consumers Camp on Elfin Lake in Wallingford had 190 people who participated and had a very positive experience.

Reducing Coercion and the Futures Program

Beth opened the discussion stating that there were two concrete suggestions from the last meeting: (1) to develop a visual framework showing the current services system and degree of coercion, and the proposed Futures services; and 2) to provide the committee with an overview of involuntary status from a legal perspective. Beth distributed a draft matrix as requested from the previous meeting..

Overview of Involuntary Care

Wendy Beinner of the AG's Office then used the matrix as a guide to describe how involuntary treatment court orders are used at various stages of the treatment process. She also discussed emergency involuntary procedures. Following is a summary of her comments:

Orders

There are two main types of involuntary treatment orders:
- OH (order of hospitalization) and
- ONH (order of non hospitalization).

In the case of hospitalization, the law sets out what must be shown for a person to be brought into a hospital against his or her own will usually for an:
- Emergency Exam (EE) or
- Observation Evaluation

Wendy reviewed the process for involuntary admission for an Emergency Examination (EE). Following the EE, the treatment provider must file with the court an AIT (Application for Involuntary Treatment) within 72 hours to continue the involuntary hospitalization. There is then a court hearing, generally within 30 days, and the court may issue an Order of Hospitalization (Commitment). Such an order is usually not sought if the person is willing to be in the hospital and receive treatment. The court order

can last up to 90 days, and may be continued for up to one year following a hearing on an Application for Continued Treatment (ACT).

In the case of Observation Evaluations, the person is admitted by the District Court for an evaluation of competency and sanity. The is completed by an independent psychiatrist, usually within 7 days. If the person is found incompetent or insane, and the person meets commitment criteria, the court may order an Order of Hospitalization (Commitment).

The Order of Non Hospitalization (ONH) is an "out-patient commitment". Most orders have conditions specific to the individual, typically requiring collaboration with a given treatment plan and/or refraining from use of drugs and/or alcohol. Generally, individuals agree to the conditions of the ONH. If, as happens, on occasion, there is no agreement a hearing is held. A hearing is held to determine whether the individual should be on ONH.

There are about 170 people on Orders of Non Hospitalization at any given time in Vermont. By comparison, there are over 3,000 CRT clients, and more than 7,000 people in adult outpatient programs. The number of people on ONH is relatively low.

Discussion:
What happens if somebody violates the conditions of an ONH? ONH conditions are somewhat difficult to enforce in that the only recourse is to re-hospitalize the individual. Re-hospitalization requires a court hearing to revoke the ONH. This hearing may take several weeks to schedule by which time in some instances, the individual reaches emergency exam (EE) status and is brought to the hospital.

Involuntary Emergency Interventions

There are three basic types of emergency interventions:

- Restraint
- Sseclusion
- Emergency medications)

These are different from Non-emergency involuntary medication.

In the case of emergency interventions, the situation must be an emergency endangering the health and safety of the individual or others. These interventions must be of short duration, require medial supervision, and are designed to restore safety. As such, these are not considered treatment.

Kitty: Do you have to ask if the individual wants a support person with them?
These are emergency situations and there is no time to get a support person.

Act 114 provides for involuntary non-emergency medication to individuals committed on an Order of Hospitalization. Act 114 is used to treat somebody's illness when, in the clinician's opinion, psychiatric medication is required for the individual to get better and

the individual refuses medication. Currently, non-emergency involuntary medication happens only at VSH. In order to give a hospitalized patient non-emergency involuntary medication the treatment provider must file an application with the Court. Witnesses (family members, psychiatrist) must testify, report on types of medication proposed, dosages, side-effects. The patient has right to have own psychiatrist to testify. The Court then may issue an order that lists specific medications and dosages, or the Court may not allow the use of involuntary medication.

Q: What if someone has an advance directive? How does that impact involuntary medications?
A: If the individual has an advance directive restricting use of medication the court cannot impose non-emergency involuntary administration of those medications. However, advance directives may not apply in emergency situations.

Q: What if the individual has a WRAP plan (Wellness Recovery Action Plan)?
Sandy, Michael, Jeff: The WRAP Plan is a clinical document (not a legal document) to help people identify what is most helpful to them. As such, it provides important guidance to providers about clients' preferences and effective recovery tools.

Act 114, the law, also permits for the state to file a request with the court to re-start medication for an individual who is on an Order of Non-Hospitalization. This has not been implemented. In such a situation, the state would file with the court, a hearing held within 7 days, and if approved, the individual would be brought to a designated hospital to receive the medication. They could be hospitalized for up to 72 hours to monitor their condition and assure no side effects from the medication. Then the individual can be returned to the community.

Jack: A couple things are pretty important: One is that most of the time people who come into the VSH or a designated hospital come in pursuant to an application for an emergency exam, are not there for legally ordered treatment. They can be held for 72 hours. They are subject to coercive detention, but not to a commitment order. If you compare the time it requires to get a commitment hearing to the usually length of stay in a designated hospital (Average Length of Stay is less than 10 days), the individual is out before the hearing. Another thing is that VSH has about 200 admissions per year. About half come through the civil process; the other half come through the criminal process for evaluation. They are not committed to the hospital until there is a court order. Maybe during that time the public defender may agree to have the person admitted to the hospital without informing his client. An application is filed for involuntary treatment and for involuntary commitment. The individual doesn't understand why they are in the hospital. We sometimes in these situations have to ask the Court to set aside the order.

JoEllen Swaine: On of the flaws in the system, from a VSH perspective is that an individual can just sit in the hospital for weeks and weeks before he or she can get a hearing for medication or for the results of the forensic evaluation.

Jack: My understanding is that forensic evaluations are happening faster now. Regarding : involuntary medication cases, the court has to hear the case within 7 days of the application being filed. People at VSH see this as a very long process. Sometimes we see cases where the doctor fills out the application but it may be a week or two before the court rules and this is viewed by staff as another court delay.

Stan: What happens in the case of Guardianship?

Wendy: The commitment process has no effect on guardianship. Very few people come into VSH that have guardians. If they did, commitment would not have any effect. The law specifically says that the order of commitment does not effect whether the individual is competent. They are separate. The law says that a Guardian cannot admit somebody to VSH.

Public Comment was taken

Further Discussion: What do we do in these treatment programs to promote choice? How is coercion reduced?

Linda: SAMHSA has a CD on this. It is very good.

Q: What happens to people in a residential treatment program, does the ONH apply? To what extent would CRR programs be doing emergency interventions?

Beth: Staff would be trained to safely contain assaultive behavior but the programs would not have a seclusion room or practice use of restraints.
Michael H: We don't have seclusion rooms. WCMHS is working on how to encourage staff to keep a negotiation going as things heat up. We have had success in de-escalating individuals who may be assualtive or who are sexually inappropriate. In situations where individuals are doing self-harm, we work with staff to coach the person not to hurt themselves but generally not to physically intervene unless the action could be immediately lethal. The objective is to try to avoid physical contact since this tends to escalate the situation. We are working with staff to make these judgments quickly and balance assessments of dangerousness with effective interventions. Any type of physical intervention requires 4-5 people to safely carry out, so we do very little of it in typical community programs.

Jackie: Have you got peer support in your programs to help "talk people down".

Michael: We plan to have peer support in the Community Recovery Residences. It is not clear how this may help in emergencies, however, the peer factor may help in other types of situations. The key issues is developing staff skills, helping them to think before they physically react, and developing relationships with clients. This is an important key in what happens. **Q:** How long are individuals in the program? **A:** Length of stay up to 18 to 24 months.

Linda: How about helping staff and clients discuss traumatization from what happened?
Michael: When we have to physically intervene we treat it as a traumatic event for the client and for staff. We process with clients (and staff) what happened.
David Fassler: Essentially the legal status or tools for Community Recovery Residences are no different than for crisis beds or other residential programs.
Wendy: Correct. An ONH allows police to bring back someone to the program, but not take him/her to the hospital. In addition, if the person on an Order of Non-Hospitalization refuses to stay in a Community Recovery Residence, the staff cannot prevent that person from leaving.

Discussion: Are we approaching the question of coercion and the policy goal of reducing it in the wrong way in this conversation?

Michael How we are talking about this situation is antithetical to what happens in practice. I would like to ask how is collaboration increased?

Think we need to ask how we set up the system, train the staff, so that collaboration is increased and coercion happens only when everything else fails. Not often that we get to lay out in a systematic way to say how the system will work. If you go now to different programs you will see that practice varies widely. I would like to take the opportunity to design the system to bring about the desired end of good treatment.

Larry Lewack: The programs on the left side of the chart are the least coercive, while those on the right increase the level of coercion. Need to focus on how to provide meaningful consumer choice and decrease coercion across the programs. Real need here is to describe some general standards that will help lay people understand how our various programs would operate. Every program should be thinking about reducing coercion. What are they going to do to give consumer choice. Not as an afterthought, but on the table from the beginning. It is up to us to come up with what those standards are. I trust the work group to write those standards and bring them back to us to work over.

Wendy: I agree with everything you have said AND I would suggest that this group should recommend to the Secretary whether the range of services that can be used in the community programs should include non-emergency involuntary medication. It is possible at VSH to get an order of involuntary medication. But should this only happen at VSH or should this also happen at an Community Recovery Residence?

Sandy: I think that in any program we can come to some meeting of the mind about how things should work. There are people for whom this (choice) doesn't always work. Then one falls back on coercive means. I think it would be good to have options. In every place always want to operate to maximize people's choices. What I worry about is how expensive the system is. There are unrecognized costs to always having choice. We need to look at the costs as well as wanting to give people as much choice as possible. It takes more time. It is expensive. If we don't look at costs we will lose our credibility.

Jeff: Some rules have to apply to any of us; like playing music too loud at night.

David F: I'm concerned that secure residential care is not on this matrix. If it doesn't happen, VSH would become the de-facto secure residential program. Also, the Actuaries report says we need 10 more inpatient general psychiatry beds. One way to reduce coercion is to increase the range of care options such as voluntary hospitalization.

Sandy: I've heard you say this before - my comment is that I don't think that the voluntary beds will reduce coercion. I worry about groups of people who WANT to be in the hospital when the clinicians feel they do not need hospital; I don't see this reducing coercion. I move to extend Act 114 to Community Recovery Residences.

Beth: I'm not sure people are ready to vote on extending ACT 114 for non-emergency involuntary medication to Community Recovery Residences. Lets bring this issue back in August; and in the meantime hear more from the work groups.

Public Comment was Taken

Next Steps
Beth summarized that the next steps include (1) working more with program staff and work groups to further develop the matrix and clinical programmatic approaches to increase collaboration

Work Groups Updates

Clinical Care Management Work Group
Draft copies of the working documents of the Clinical Care Work Group: Introduction to Change of Level Criteria (April 25, 2006) and Rules for Change in Levels of Care (April 28, 2006) were distributed.

VSEA Work Group: Connor reported that this group is still exploring a range of options.

Housing Development Jeff reported that the group had met and was looking at different types of housing. The consensus was that $400,000 was a drop in the bucket but the group decided to soldier on.

Crisis Beds: Jeff reported group has been looking at different crisis programs (there are 4), and is nearly finished a survey of CRT and Emergency programs and each of the Designated Hospitals to ask where they see the need for crisis beds.

Architectural Facilities Work Group: Beth reported that group is looking at initial options for the primary inpatient facility at FAHC.

Community Recovery Residence: Michael reported the work group will meet in August. The program implementation in Williamstown is going well.

Peer Services Work Group: Nick Nichols of the DMH staff has agreed to lead a work group to develop peer services. Several committee members volunteered to work with him on this.

Other Updates

Letter of Intent for Conceptual Certificate of Need was submitted to BISHCA on June 19, 2006. Copies of the document were distributed to the group.

Work with the City of Burlington and Neighboring Communities Beth reported plans to meet with Burlington Housing, Health and Human Services representatives this week. This will become another working group. In addition, we will hold two public hearings in Burlington on July 13 and in South Burlington on July 20. We will ask for volunteers to form a task force to examine the options for siting new psychiatric inpatient beds on the FAHC campus.

Certificate of Approval process: Dawn Philibert distributed the current and proposed certificate of approval process. She welcomes any comments by email or phone.

Additional public comments were taken

Meeting adjourned at 4:30 p.m. Next meeting August 7.